STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E882	A. BUILDING _____ B. WING _____	02/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK CENTER	919 WASHINGTON PARK WAUKEGAN, IL 60085

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 13 taken or recorded.	F 371		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These REGULATIONS are not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to supervise and consistently implement their current smoking program and failed to re-assess and respond	F9999		

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F9999	Continued From page 14 timely to 14 probable residents either found smoking in unsafe areas or with evidence of unsafe smoking in their rooms thereby putting all 209 residents at risk. The facility failed to supervise residents noted to have smoked or suspected of smoking in unsafe manner and update a plan of care and provide increased supervision after each smoking infraction. Surveyors noted evidence of smoking in various resident rooms during tour on Sunday 2/22/09 by strong cigarette odors and evidence of cigarette butts on the floor by resident beds and by their bathrooms. Surveyor noted active smoking in the rooms for R12 and R13. The facility houses primarily mentally ill residents and does not allow smoking in the resident rooms. Findings Include: Upon entering the facility at 1:50 pm, on 2/22/09 the receptionist was the only staff out in the milieu noted. The first floor nurse was in her medication rooms, and there were no staff noted anywhere on the hall or in the dining rooms for both first floor and second floor. Residents were noted unsupervised in the dining room, the hallways and the shower room, and many were in their rooms. The initial tour was then started without escort on 2/22/09 at 2:00 pm. R13 was observed smoking in his room while sitting on his bed at 2:40 pm. Four staff found in the nursing station were notified of surveyor observation. Staff came back	F9999		

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F9999	Continued From page 15 with surveyor into the room and resident was still smoking, but had moved to his chair. Surveyor also noted additional evidence of smoking such as cigarette ashes and butts on the floor and in R13's bathroom. Staff took the cigarette and lighter away. R13 got upset about staff action complaining to surveyor that he "has been smoking in his room before and they have never done this." In fact, after this incident, R13 required a prn medication and was sent to emergency room later that evening indicating that staff were not always consistently implementing this approach to R13 when found smoking. Review of R13's record reflects diagnosis of COPD (Chronic Obstructive Pulmonary Disease). R13's care plan shows R13 as not being allowed to smoke because of this health issue. Surveyor reviewed the medical chart of R13 the next day, 2/23/09, to see whether a review or change of plan was made by the facility after the smoking infraction was noted the day before. There was no documented incident of smoking for the whole day of 2/22/09 nor any documented PRSC follow-up. R12 was observed smoking while lying on his back at 2:43 pm 2/22/09. Staff who were in the nurse's station were called to the room. R12 scurried out of his bed to his bathroom to get rid of the cigarette. The room was still filled with fresh smoke. R12 was asked about smoking--which he denied. Staff were told that he was observed smoking in his bed.	F9999		

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F9999	Continued From page 16 Review of R12's chart the next day, 2/23/09, also showed no documentation of the incident, no intervention provided, and and no up-date or re-assessment after the infraction. Current care plan did identify R12 with history of non-compliance with smoking. Interventions include, "if resident is found smoking in undesignated areas, remove materials and counsel." No evidence noted in documentation this was done. During the initial tour 2/22/09 from 2:00 pm to 3:00 pm, the following rooms had evidence of smoking in the rooms, including strong cigarette smoke smells which were noted from the hallway, cigarette ashes on the floor, or on the toilet basin or bowl and cigarette butts on the floor: Rooms included 112, 204, 208, 303, 304, 307, 310, 406, 407, 410 and 413. Staff noted walking the hallways did not come in to check on the strong cigarette smoke smell coming out of each room. After notification of staff regarding R13's behavior of smoking in the room, the staff were told about concerns regarding many resident rooms having evidence of smoking. Review of residents records in these rooms show no follow-up on their possible non-compliant behaviors. Surveyors reviewed current smoking plan followed by facility. It was determined that present facility smoking approaches were not applied consistently and timely in safeguarding the facility residents from danger of inappropriate and unsupervised smoking. Many residents were identified as problem smokers, but there was no consistent evidence that residents were	F9999		

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F9999	Continued From page 17 counseled, supervised, or approaches up-dated after unsafe smoking continued. Residents and resident rooms identified with smoking materials were on Level 1 supervision and really had no pass access to obtain smoking materials. E1 admitted that in many cases other residents supplied the Level 1 residents with cigarettes. When asked for documentation, nothing was provided to show facility action on this initial observation. E1 stated that he is aware that family and other residents contribute to the problem of unsafe smoking in the facility and that many residents go to other resident rooms to smoke, making it difficult to identify the smokers just from room observations. (A)	F9999		